CLINICAL GUIDELINE

Uterine Artery Embolisation (UAE) for patients attending for pre, intra and post procedure, Gynaecology

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Does this version include changes to clinical advice:	No
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Lead Author:	Andrew Christie
Approval Group:	Gynaecology Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Protocol for the pre-, intra- and post- procedure management of patients attending for uterine artery embolisation (UAE)

Bloods (FBC/U&E/coagulation) are **NOT** required, unless the patient's Past Medical History dictates - at the discretion of the ward doctor clerking the patient.

Post- procedural ward observations -

- Post Embolisation Syndrome – manifesting as pain and pyrexia
- Groin haematoma relating to the common femoral artery groin puncture (right side; very rarely bilateral). Incidence of ~ 1%
- A Consultant Interventional Radiologist can be contacted 24/7 via switchboard with any concerns

Analgesia plan – Pre-operative checks

Identify any contraindications to nonsteroidal anti-inflammatory drugs (NSAID) e.g. renal failure, clotting abnormalities. If the patient describes a history of Gastro-oesophageal Reflux Disease (GORD) consider Omeprazole 20mg daily as cover for NSAID therapy.

Procedure – Pre-operative prescription

- Oxycodone 10mg prolonged release at least 1 hr before the procedure & after formal written consent has been obtained
- Diclofenac immediate release 50mg orally
- Ondansetron 8mg orally
- Paracetamol 1G orally (consider 500mg if weight < 50kg)
- Dexamethasone 8mg orally
- Omeprazole 20mg orally if required

Intra-procedural therapy

- Midazolam titrated as per protocol
- Morphine 10mg subcutaneously at commencement of embolisation
- Fentanyl titrated as per protocol (max. 200 micrograms)
- Morphine 10mg subcutaneous on removal of vascular sheath, but only if > 1hr since last dose

Post-procedure – Regular prescriptions

- Oxycodone 10mg prolonged release orally at 10pm
- Diclofenac 50mg 8 hourly from 10pm
- Paracetamol 1G 6 hourly orally (consider dose reduction if weight < 50kg)
- If patient vomiting, consider changing to IV or PR paracetamol. Consultant prescription for IV must be obtained. Change back to oral route once vomiting stopped. Again, adjust dose accordingly if weight < 50kg.
- Ondansetron 4mg orally/IV 8 hourly (regularly to prevent nausea)

Post-procedure – As Required Prescription

- Oxycodone 5mg immediate release
- Cyclizine 50mg oral/IV/IM 8 hourly (prescribe to actively treat nausea to prevent vomiting)
- Prochloperazine 6mg Buccal 12 hourly (prescribe to actively treat nausea to prevent vomiting)

Discharge medication

5 day supply

- Cocodamol 30/500 tabs. 2 tablets 4 to 6 hourly as required (consider dose reduction if weight < 50kg)
- Diclofenac 50mg orally 8 hourly
- Omeprazole 20mg daily if required for duration of NSAID therapy only

Contact details in case of urgency

In hours – Andy Christie 07969751167

Ram Kasthuri 07813182983

Interventional Hub at QEUH 83607

Out of hours – oncall consultant via switchboard

Available 24/7

Prototype updated July 2017 by Dr Andrew Christie, Consultant Interventional Radiologist & Lesley Kelly, Ward Sister.